Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALLIED MEDICAL CENTERS
PO BOX 24809
HOUSTON TEXAS 77029

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
ALIEF ISD

Carrier's Austin Representative Box
Box Number 21

MFDR Tracking Number
M4-11-0816-01

MFDR Date Received
November 5, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "TDI rule states that it is not enough for a carrier to file a TWCC denial code and that the carrier is required to submit claim specific language. Although the denial is understandable: it does not apply to these DOS or this claim. The denial code and their description are too vague for our facility to determine the basis for the denial. This denial is not in compliance with Rule §133.3."

Amount in Dispute: $218.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not respond to the DWC060 request. A copy of the DWC060 was placed in the carrier representative box 21 on November 18, 2010. The insurance carrier representative, Avee Chandlers picked up and signed for the copy of the DWC060 request on November 20, 2010. A decision will therefore be issued with the information presented to MFDR for review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 6, 2009, November 12, 2009 and November 16, 2009	98940	$218.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the professional fee guidelines.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 27, 2010
   - W1 – Workers compensation state fee schedule adjustment.

- 309 – Your documentation of extraordinary circumstances does not justify the use of ML104. The evaluation does not meet the criteria listed in Rule 9795(C) ML104.
- 216 – The charge for this procedure exceeds the fee schedule allowance.

Issues

1. Did the requestor submit documentation to support that the services were rendered as billed?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203(b) "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
    - The requestor billed CPT code 98940 on November 6, 12 and 16, 2009.
    - CPT code 98940 is defined as follows: "Chiropractic manipulative treatment (CMT); spinal, 1-2 regions."
    - The SOAP notes submitted by the requestor were insufficient to support that the services were rendered as billed.
2. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for CPT code 98940 rendered on November 6, 12 and 16, 2009.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 14, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.